Pharmacare 2020?

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Dear Colleagues,

Canada is one of few Organisation for Economic Co-operation and Development countries that does not have a national program for public coverage of medicines (others being Israel, Mexico, and the United States).[1] Recommendations in favour of national pharmacare have emerged from reports and consultations over the years.[1-4] The CFPC is on record as supporting universal pharmacare. With Dr Eric Hoskins' appointment as Chair of the Advisory Council on the Implementation of National Pharmacare, and a fall election under way, further conversation could be important.

The advisory council has defined pharmacare as "a system of health insurance coverage that provides people with access to necessary prescription drugs."[2] To some extent, universality is included—covering everyone. At the same time, there is recognition that the terms and structure of insurance plans need to be considered (eg, "necessary" medicines).

Canada spent $34 billion on medicines in 2017, 43% through public coverage, 36% through private coverage, and 23% out of pocket.[1] All provincial plans provide some form of coverage for those older than 65 and those receiving social assistance; 60% of Canadians have private insurance.[1] Including other forms of coverage (eg, for those younger than 24 in Ontario, for cancer and palliative care in some provinces), more than 80% of Canadians have some form of drug coverage. However, at least 5.5% of Canadians skip, extend, or do not fill their prescriptions.[1] Not surprisingly, they are among our communities' most vulnerable citizens. Let's look at the options from the perspective of access, value for money, and acceptability to patients and providers.

Comprehensive coverage: This would provide access to everyone and be funded by the public purse. This model has strong support from many Canadians, is the most costly, and transition and management would be complex. Employers currently providing employee insurance might or might not save money; employers not providing coverage might be required to contribute financially through taxes or other levies.

Public coverage of essential medicines: This is based on the World Health Organization's list of 125 essential medicines.[5] Most current classes of medicines are included, resulting in enhanced access to medication coverage; through a common formulary and bulk purchasing, some savings could be achieved; physicians would be encouraged to use lower-cost prescription drugs. Increased public spending would be required, and the model would not fully replace current public or private coverage. Most medications used in community-based care would be covered; the speed of introduction of new medications and their inclusion on the formulary would need to be managed. Public support for this model is mixed. The Canadian Medical Association conducted a member survey and is on record as supporting this model.[6]

Public coverage with income-based deductibles: Forms of this model currently exist in several provinces. Depending on how it is structured, coverage for lower-income households could be improved, as long as they are exempt from the deductible; the model has had mixed reviews, in part because it is complex to administer.

Individual mandate: This model is used in Quebec. (Of note, Quebec has the most generous public formulary in the country.) It is a premium-based public plan for those who do not have private insurance, with the premium based on income. Access is enhanced for those without coverage; value for money is not particularly improved; it can result in considerable differences in level of coverage; and it is complex to administer.

Optional public coverage: This model is used in Alberta for those younger than 65. It involves premium-based enrolment that improves access for those with no coverage; value for money is not necessarily enhanced, but it is less demanding on the public sector and least disruptive for those with coverage.

As you can appreciate, there are many factors to consider: options that are most equitable; individual choice; effects on employers, with potential economic repercussions; effects on private insurers; level of public spending; and whether Canadians continue to subscribe to the egalitarian notion of "looking after one another" through sound public policy.

The CFPC has long advocated for national pharmacare. At the time of writing, we have been informed that the federal government will provide us with an indication of a level of support for pharmacare in the upcoming budget. In informal conversations with FPs, I sense support for an intuitive system to administer, with minimal paperwork, and an easy process to request coverage of medications that might not be on the formulary. We are awaiting more details about the selected option or options and how they will truly enhance access, support a degree of choice and innovation, and be fiscally sustainable, while minimizing effects on providers. Ultimately, this is about achieving better health outcomes and tangible, measurable improvements in quality of life for all people in Canada. We are interested in your thoughts about this issue. Do you support a national pharmacare program? If so, do you have a preferred option or options? Please tell us what you think by posting a Rapid Response to this article online.

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References

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6. *Implementation of national pharmacare. Submission to the Advisory Council*. Ottawa, ON: Canadian Medical Association; 2018.